Washington State Department of Health

Massage Practitioner License Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Board of Massage Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly. It is your responsibility to submit the correct required forms.

☐ **Application Fee**. This fee is **non-refundable**. You can check the **fee page** for current fees.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification or Registration:**
List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.

☐ **4. Professional Education:**
List in chronological order your educational preparation and post-graduate training. If you need more space, attach a piece of paper.

☐ **5. Professional Experience:**
List in chronological order all professional experience and practice from date of graduation from professional college. If you need more space, attach a piece of paper.

☐ **6. AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by **WAC 246-12-260**. Course content can be found in **WAC 246-12-270**.

☐ **7. Applicant's Attestation:**
You must sign and date this for us to process the application. Read this very carefully.

☐ **8. Applicant's Photograph:**
Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and a front view. Your application will not be processed without a current photograph.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

Washington State Department of Health

License Requirements

Thank you for applying to become a licensed massage practitioner in Washington State. To expedite the license process, you must include the following:

- Completed Jurisprudence Exam

The following require primary source verification and will only be accepted when mailed directly to the department from the source. These items should **not** be included with your application. They should be sent directly to the Department of Health, Massage Program, PO Box 47877, Olympia, WA 98504-7877.

- An original school completion form stamped and signed by the registrar from an approved Washington State massage program or apprenticeship. Form is included in packet.
- Official exam score report from the NCBTMB or FSMTB.
- The certification of license and examination form from a Washington State Massage Board approved jurisdiction. If you are currently credentialed in a Washington State approved jurisdiction, you do not need the previous two items.
- CPR and First Aid. Submit a photocopy, front and back, of your current Red Cross First Aid card and American Heart Association CPR card (or equivalent) showing the expiration dates. These are not needed if this information is included on your school completion form.

Criminal history checks are conducted for all massage license applicants. If you answered yes to any of the personal data questions, please submit the appropriate supporting documentation as indicated on the application.

- The application is considered incomplete if requested information is left blank. Write N/A or put a line through section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See **WAC 246-12-020**(3).
- You will receive a courtesy renewal notice if your license and address are kept up to date. Any renewal postmarked or given to the department after midnight on the expiration date is late.

Note: You cannot practice massage until your license is issued.

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 024201000

Massage Practitioner License Application

Please type or print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could result in a delay in processing your application. Make sure you have read the instructions.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.) ☐ Male ☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth: City | State | Country

Address

City | State | Zip | County

Country

Phone (Enter 10 digit #) | Fax (Enter 10 digit #) | Cell (Enter 10 digit #)

Email address

Mailing address (if different from above)

City | State | Zip | County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

License # _____ Issue date _____

Validation date _____ Received _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐
   b. Diverted controlled substances or legend drugs? ..... ☐ ☐
   c. Violated any drug law? ..... ☐ ☐
   d. Prescribed controlled substances for yourself? ..... ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ..... ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

3. Other License, Certification, or Registration

List all states including Washington where licenses/certifications/registrations are or were held.

State	License/certification/registration type	License/certification/registration		Method of license		
		Year Issued	Number	Exam	End	GF

4. Professional Education

Provide a chronological listing of your educational preparation and post-graduate training. If you need more space, attach sheet of paper.

Schools Attended Full Name, City and State	Degree Earned	Attendance	
		From (mm/dd/yyyy)	To (mm/dd/yyyy)

5. Professional Experience

List in chronological order all professional experience and practice from date of graduation from professional college. Include the month/day/year. If you need more space, attach a sheet of paper.

Type of experience and location	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

6. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

8. Applicant's Photograph

Photo Here

Attach Current Photograph Here.
Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

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Washington State Department of Health
Board of Massage Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

License and Examination Certification

To applicant:

Complete top part of form and send it to all state and/or jurisdiction where you are licensed. Instruct them to return the form directly to the address listed above. Make a copy of this form if you are licensed in more than one state and/or jurisdiction. Licensing agencies normally charge a fee to verify a license. Check in advance to help expedite this process. For questions, call 360.236.4700.

Name _____ List other names used: _____

Address _____

City _____ State _____ Zip _____

Massage program name completed _____

Massage license number: _____ Date Issued: _____

(To be completed by the State and/or Jurisdiction)

To the Licensing State and/or Jurisdiction:

Please complete this form about the applicant listed above. Send a copy of your current statutes and an outline of the examination the applicant took. Submit the information and this form to the address above. Thank you.

Name of licensed practitioner _____

Authority providing verification _____

Name of massage program completed _____

Hours required _____ Date completed _____

Applicant was licensed by _____

Written examination _____ Date _____ Score _____

Other examination _____ Waiver _____ Year _____

Is license current? ☐ Active ☐ Inactive Expiration date _____

Has this license ever been: ☐ suspended ☐ revoked ☐ surrendered _____

(If yes, please provide a copy of final order(s) or other documentation.)

Seal

Signature _____

Date _____

Title _____

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Washington State Department of Health
Board of Massage Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Board of Massage School Completion form

Please use blue ink to complete this form

If your school offers more than one massage program or if there is more than one campus, each individual campus and/or program must be approved by the Board of Massage. The school program or campus must be approved before the applicant's graduation date. If an applicant did not graduate from a Washington State Board approved campus or program, they are not eligible for license.

Candidate name _____ Check if candidate completed transfer program ☐

Board of Massage Approved Training Program

Name of school_____

Name of approved program_____

Some schools offer more than one program. Approved program name is required.

Entry date of program _____ / _____ / _____

Date program completed _____ / _____ / _____

Number of hours completed _____

The student must complete the school hours approved by the Massage Board.

Place Washington State Board Approved School Stamp below **(form is not valid without number stamp).**

Note: To be licensed with the state of Washington, applicants must meet the training requirements as outlined in WAC 246-830-430 titled Training, which states "These five hundred hours are not to be completed in less than six months."

School registrar or representative authorized signature _____

Date training completed_____

Note: Only school completion forms sent directly from the school to the Washington State Department of Health will be accepted.

First Aid/CPR/AIDS Training

		Date training completed mm/dd/yyyy
First aid _____	Training provided by _____	_____/_____/_____
CPR_____	Training provided by _____	_____/_____/_____
AIDS education _____	Training provided by _____	_____/_____/_____

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Health Professions Reference Numbers and Links

RCW/WAC Links

Uniform Disciplinary Act..... **UDA RCW 18.130**

Administrative Procedure Act .....**APA RCW 34.05**

Administrative procedures and requirements ..... **WAC 246-12**

AIDS Courses

Health Impact .....1.800.783.2437 **or** 206.284.3865

W.F. Professional..... 1.800.323.4305

AIDS Resources 206.784.5655

On-Line

Board of Massage ..... **Web Page**

National Certification Board..... **www.ncbtmb.com**

AIDS Training ..... **Reference Page**

Federation of State Massage Therapy Boards..... **www.fsmtb.org**

Washington State Approved Massage Programs..... **School List**

Jurisprudence Exam..... **Link**